

Registration District No. 526

Primary Registration District No. 4712

Registrar's No.

1. PLACE OF DEATH: *Macon*
(a) County *Macon*
(b) City or town *Atlanta*
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether)
In this community
years, months or days

3. (a) PRINT FULL NAME *Perry Armstrong*
(b) If veteran, name war
(c) Social Security No.

4. Sex *Male* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Widower*
(b) Name of husband or wife
(c) Age of husband or wife if alive *years*
7. Birth date of deceased *Macon 22-1855*
(Month) (Day) (Year)

8. AGE: Years *85* Months *24* Days *0* If less than one day
hr. min.

9. Birthplace *Macon Co., Mo.*
(City, town, or county) (State or foreign country)

10. Usual occupation *Retired Farmer*

11. Industry or business

12. Name *Robert Clelland Armstrong*
13. Birthplace *Kentucky*
(City, town, or county) (State or foreign country)

14. Maiden name *Mary E. Shepherd*
15. Birthplace *Kentucky*
(City, town, or county) (State or foreign country)

16. (a) Informant *W. G. Armstrong*
(b) Address *K. G. State, Mo.*

17. (a) *Burial* (b) Date thereof *Jan 17-1941*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Wt. Curran*

18. (a) Signature of funeral director *Stephen B. Breding*
(b) Address *Macon Mo*

19. (a) *Jan 24 1941* (b) *Wm. McNeely*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: *61*
(a) State *Mo* (b) County *Macon*
(c) City or town *Atlanta Mo*
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. *0* years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* day *15*
year *1941* hour *4* minutes *55* a. M.

21. I hereby certify that I attended the deceased from *Jan 8*
19*41*, to *Jan 15*, 19*41*
that I last saw him alive on *Jan 14*
and that death occurred on the date and hour stated above.
Immediate cause of death *Thromb*
Duration
Due to *Thromb*
Due to
Other conditions *Senility*
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
469 (Specify type of place)
While at work? (e) Means of injury

23. Signature *G. G. Lyda* (M. D. or other) *1*
Address *Atlanta Mo* Date signed *1-18-41*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 2-41-294

Date Filed FEB 14 1941

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

H. M. Gunning
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No. 1756

P. O. Address Atlanta, Ga.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.